

"nature" to see things white as good and black as bad yesterday. A new tradition has made many of us see black as beautiful today.)

These are only random examples of well known questions, which could be answered by an equally well known method: Scientific experiment.

Unfortunately, the temptation to engage in easy moralizing is often irresistible — as this letter proves once more. Can we all resolve to publish data rather than exhortations the next time around?

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## A Way to Make More Medical "Schools"

*To the Editor:* No expansion short of doubling our medical schools' graduating classes is going to do more than maintain the present physician-population ratio. Even the most optimistic realize that by using the customary channels—larger grants, larger classes, larger physical plants, new medical schools, larger faculties, etc., there can be no net gain in the supply of doctors in less than ten years.

There is, however, a relatively simple way that would provide immediate relief to some over-worked doctors, an absolute doubling of physician graduates in four years, besides better trained graduates.

Simply realize and capitalize on the fact that there are as many practicing physicians and/or hospital staffs as there are medical students who could give students adequate clinical teaching and experience away from the confines of medical schools.

We could begin the regular number of freshman medical students this fall. After six months of classroom work, preceptorship them out to carefully screened active doctors' offices, medical groups, and/or hospital staffs for six months, and admit a second freshman class of equal numbers.

By thus alternating six months of classroom work with six months of high quality on-the-job-training throughout the four years, not only would these graduates be as well or better equipped for

practice, but they would also have helped ease the doctor shortage from their first year of medical school.

The stage is ripe for legal licensing of a new level of physician assistants. Certainly there could be no better physician assistants than medical students advancing in training and responsibility under legal licensure throughout their medical course.

Besides the actual valuable experience of studying and helping with a busy private practice, staff meetings, teaching rounds, pertinent lectures, etc., are available to the preceptee in every medical community.

Still another plus is the fact that the student as a salaried physician assistant could defray at least a part of the medical school expenses. This would automatically open the way for more medical student prospects from the lower income levels.

It would be understandably difficult for deans and curriculum planners to see the full merit of an educational plan so drastically different from what they have painstakingly and skillfully evolved over the years. Therefore, to institute this or any other radical change, the ball probably will initially have to be picked up and carried by those not at present directly involved with medical school curriculum planning.

If this is not a feasible plan or if there are better alternative ways of immediately doubling our medical school enrollment, let's hear it.

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## Costly Mythology In Health Care

*To the Editor:* Your article *Costly Mythology in Health Care* [(Editorial). Calif Med 112:81-82 Mar 1970] has the one salutary effect of making one think about your statements.

You label as a myth the fact that "Scientific medicine can bring good health if it is readily available and used correctly." That fact must be questioned and corrected.

Scientific medicine has brought good health where it has been properly applied. Especially noteworthy are the areas of Preventive Medicine:

infectious diseases, inoculations, vaccinations, antibiotics and mass screening as in tuberculosis. A remarkable savings in direct and indirect cost has been calculated<sup>1,2</sup> by the use of the pap smear in cervical cancer.

Medical science is not an exact science, but is rapidly becoming more exact. The speed of scientific advance is partly related to accurate records and partly related to provable theories. The latter cannot advance without the former. The computer has the capability to standardize and simplify and nationalize medical record keeping. Scientific advances are often related to improved tools and more accurate measuring devices: microscope, roentgen tube, ECG. Have we reached the end of new devices, tools or theories?

Exciting new theories relating psychiatry and sociology to sound medical practice may yield important changes in morbidity statistics. Some diseases are individual—smallpox. Some are family diseases—anxieties, peptic ulcers, battered child. Some are national—riots, divorce, and drug abuse.

The scope of medicine and its horizons must enlarge until we solve the problems of the diseases of degeneration and psychiatric disabilities. This can best be done by improving the science of medicine and the availability of health care.

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#### REFERENCES

1. California Medical News, Nov, 1968
2. Grimaldi JV: The worth of occupational health programs—A new evaluation of physical examinations. *J Occup Med* 7:365-374, 1965

#### HYPOGLYCEMIC COMA

"The important thing about hypoglycemic coma is to suspect it. The brain, partially because it doesn't have any glycogen, is very vulnerable to low blood sugar and gets into trouble very promptly. It's important to note that hypoglycemia does not have to present as coma. It may present as delirium; occasionally it may present as a hemiplegia. There are instances in which people become hemiplegic on one side in one hypoglycemic episode and on the other side in another episode. Some of these patients with focal signs do not show any focal cerebral disease at autopsy. Why they are hemiplegic instead of comatose is not clear. It's probably a wise general rule in dealing with a coma state of unknown etiology to administer intravenous glucose until a blood sugar is available."

—STANLEY VAN DEN NOORT, M.D., Cleveland  
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